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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09780

9771

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rural Grantsville</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		OR TOWN <u>Rural Grantsville, Md.</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>JAMES</u> (Middle) <u>WESLEY</u> (Last) <u>BITTINGER</u>				<u>Oct. 20</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 29, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>George Creek Area, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bittinger</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Broadwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>212-18-1465</u>		17. INFORMANT & ADDRESS <u>Mrs Della Bittinger, Grantsville,</u>			
(If Yes, give war or dates of service)							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
152X IMMEDIATE CAUSE (A) <u>Carcinoma of the small intestine</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>indolent growth involving cecum</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/15</u> , 19 <u>55</u> , to <u>10/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>55</u> , and that death occurred at <u>6:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>A. Paige Strong</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Pa.</u> DATE SIGNED <u>10/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bittinger</u>		LOCATION (City, town, or county) (State) <u>Bittinger, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR <u>10-22/55</u>		REGISTRAR'S SIGNATURE <u>Ethel Broadwater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	

BUREAU V.

5561 82 120

Wm. H. Wood

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9772

CERTIFICATE OF DEATH

09781

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Rural Grantsville</u>		<u>life</u>		TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DEBRA</u>		(Middle) <u>LYNNE</u>		(Last) <u>BOWSER</u>		(Month) (Day) (Year)	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>single</u>		<u>July 24, 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>infant</u>		<u>Meyersdale Community Hosp.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Luther Bowser</u>				<u>Dortha Elleen Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>(If Yes, give war or dates of service)</u>		<u>none</u>		<u>Mrs Robert Bowser, Grantsville, R.D. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>571.0</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>acute gastro enteritis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 24</u> , 19 <u>55</u> , to <u>OCT 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>OCT 26</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Leonard L. Lock</u> M.D.				<u>Meyersdale Pa</u>		<u>10/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/28/55</u>		<u>Zion Lutheran</u>		<u>Accident, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/27/55</u>		<u>Ethel Broadwater</u>		<u>Donna Newman</u>		<u>Grantsville, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09782
9773 CERTIFICATE OF DEATH Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Garrett.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Friendsville</u>				OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Nettie A Coddington.</u>				<u>Oct 30, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widow</u>	<u>Oct 30, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>				<u>Garrett Co, Maryland.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Addison Frazee</u>				<u>Caroline Harden.</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Earl Coddington</u>		<u>Friendsville, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Coronary THROMBOSIS</u>						<u>5 min.</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE <u>No</u>		INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Aug 6</u> , 19 <u>55</u> , to <u>Oct 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 29</u> , 19 <u>55</u> , and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE) ADDRESS		DATE SIGNED	
<u>Weldon Tepper, M.D.</u>				<u>Friendsville, Md</u>		<u>Oct 31, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-2-55</u>		<u>Addison Cemetery.</u>		<u>Addison, Pa</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct 31 1955</u>		<u>Mrs Ruth Frantz Deputy</u>		<u>H. B. Pischelberger</u>		<u>ADDISON, PA.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH
9774
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09783

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Barnett</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Friendsville</u> TOWN <u>Friendsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>53 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Barnett</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u> OR TOWN <u>Friendsville</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>STANLEY</u> (Middle) <u>JENNINGS</u> (Last) <u>FRIEND</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1955</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Feb 23, 1902</u>	
9. AGE last birthday <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, state) <u>miners. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Friendsville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Josephus Friend</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza Ellen Stark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY No. <u>217-07-8653</u>	
17. INFORMANT AND ADDRESS <u>Beard McCullough - Friendsville, Md</u>		18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>434.3</u> Immediate cause (a) <u>Heart disease - probably failure</u> Antecedent cause(s) (b) <u>Heart attack July 54</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE Thomas D. Lushy (Degree or title) ADDRESS 14 S. Calhoun, Md. DATE SIGNED 10/30/55
 23. BURIAL, CREMATION OR DISPOSAL (Specify) Burial DATE THEREOF Nov. 2, 1955 NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery LOCATION (City, town, or county) (State) Listonburg, Pa.
 DATE REC'D BY LOCAL REG. Nov. 1, 1955 REGISTRAR'S SIGNATURE Mrs Ruth Frantz 24. FUNERAL DIRECTOR Jack A Friend Friendsville, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 8 1955

RECEIVED

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10864

9775

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>OAKLAND</u>		<u>4 weeks</u>		TOWN <u>ACCIDENT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CLEMENS C. GOEHRINGER</u>				<u>OCTOBER 27 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SEP.</u>	8. DATE OF BIRTH <u>8/30/1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER & BUS DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ACCIDENT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>WILLIAM GOEHRINGER</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Lockner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>AUBRA GOEHRINGER ACCIDENT, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
157X IMMEDIATE CAUSE (A) <u>Malnutrition</u>						<u>8 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA HEAD OF PANCREAS</u>						<u>7 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>April 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Head of Pancreas</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 30, 1955</u> , to <u>Oct 27, 1955</u> , that I last saw the deceased alive on <u>Oct 27, 1955</u> and that death occurred at <u>10:58 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Smith</u>				ADDRESS (Street, city, town, state) <u>M.D. 58 2nd St. Oakland Md</u>		DATE SIGNED <u>10-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		LOCATION (City, town, or county) (State) <u>Accident, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR <u>10/29/55</u>		REGISTRAR'S SIGNATURE <u>Julia A Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phorald F. Newman</u>		ADDRESS <u>Grantville, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH

6. MARITAL STATUS
7. OCCUPATION

8. CAUSE OF DEATH
9. MANNER OF DEATH

10. DATE OF DEATH
11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESS

15. SIGNATURE OF WITNESS

16. SIGNATURE OF WITNESS

17. SIGNATURE OF WITNESS

18. SIGNATURE OF WITNESS

19. SIGNATURE OF WITNESS

20. SIGNATURE OF WITNESS

21. SIGNATURE OF WITNESS

22. SIGNATURE OF WITNESS

23. SIGNATURE OF WITNESS

24. SIGNATURE OF WITNESS

25. SIGNATURE OF WITNESS

26. SIGNATURE OF WITNESS

27. SIGNATURE OF WITNESS

28. SIGNATURE OF WITNESS

29. SIGNATURE OF WITNESS

30. SIGNATURE OF WITNESS

31. SIGNATURE OF WITNESS

EXHIBITION

BUREAU V. S.

NOV 8 1955

RECEIVED

9776

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CRELLIN</u>		<u>1 WEEK</u>		TOWN <u>CRELLIN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>STELLA</u> (Middle) <u>MAE</u> (Last) <u>HADDIX</u>				(Month) <u>OCT.</u> (Day) <u>26</u> (Year) <u>1953</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JULY-10-1895</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>				<u>SWALLOW FALLS MD</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY M. SCABE</u>				<u>MAHALIA KEISNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>SAMUEL HADDIX CRELLIN MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BLINDNESS</u>				<u>5yr</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>45</u> , to <u>Oct.</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>53</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Samuel Haddix</u> M.D.				ADDRESS (Street, city, town, state) <u>Oakland MD</u>		DATE SIGNED <u>10/27/53</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT-28-1953</u>		<u>ASHBY CEMETERY</u>		<u>NEAR CRELLIN MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/28/53</u>		<u>Julia Chovan</u>		<u>Samuel Haddix</u>		<u>Oakland MD.</u>	

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit. VS A15C 1-55 10M

CERTIFICATE OF DEATH

GARRETT
CRELLIN
WEEK
M/D
GARRETT
CRELLIN

STELLA
FEMALE WHITE
HOUSEWIFE
HENRY M. CABE
MARRIED JULY-10-1912
WIFE
WAS
HADDIX
OCT. 4
SWALLOW TAILS MD U.S.
WYOMING KEISNER
SAMUEL HADDIX CRELLIN MD

BUREAU V. S.

19
OCT-2-1925
ASHBY CEMETERY NEAR CRELLIN MD
Buried in Ashby Cemetery near Crellin, Md.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9777

CERTIFICATE OF DEATH

09785
166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>OAKLAND</u>		<u>7 Days</u>		TOWN <u>CUMBERLAND</u>		<u>01X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE 3, BEDFORD ROAD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u>		(Middle) <u>S.</u>		(Last) <u>HOLAHAN</u>		(Month) (Day) (Year) <u>OCTOBER 5 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>DIVORCED</u>	<u>December 21 1880</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Lawyer</u>		<u>Practicing Law</u>		<u>Troy NEW YORK</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HOLAHAN, HUGH</u>				<u>GAY, JOSEPHINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>MRS. W. S. RELING Cumberland Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 Days</u> <u>7 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>4 Oct 1955</u>		<u>M.</u>		<u>2:45 AM</u>			
22. I hereby certify that I attended the deceased from <u>31 Sept 1955</u>, to <u>5 Oct 1955</u>, that I last saw the deceased alive on <u>4 Oct 1955</u>, and that death occurred at <u>2:45 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>W. S. Reling</u>				ADDRESS (Street, city, town, state) <u>Oakland Md</u>		DATE SIGNED <u>5 Oct 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 7 1955</u>		<u>St. Mary's Cemetery</u>		<u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/6/55</u>		<u>John G Rowan</u>		<u>W. H. Knight</u>		<u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

2553

1. NAME OF DECEASED JOHN J. BROWN		2. SEX Male		3. AGE 47	
4. PLACE OF BIRTH BALTIMORE, MARYLAND		5. OCCUPATION Carpenter		6. MARITAL STATUS Married	
7. DATE OF DEATH November 8, 1935		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.	
13. SIGNATURE OF REGISTRAR A. B. Jones		14. SIGNATURE OF WITNESSES C. D. White, E. F. Green		15. SIGNATURE OF DECEASED John J. Brown	

BUREAU V. S.

NOV 8 1935

RECEIVED

1. This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the person who has taken charge of the funeral, or by the person who has taken charge of the burial, or by the person who has taken charge of the interment, or by the person who has taken charge of the cremation, or by the person who has taken charge of the other disposition of the body.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9778

CERTIFICATE OF DEATH

09786

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u> <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		TOWN <u>01-02-2</u>	
CITY OR TOWN <u>Oakland</u>		LENGTH OF STAY (in this place) <u>3 Mo</u>		STREET ADDRESS <u>219 Maryland Ave</u>		(If rural give location) <u>✓</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>				3. NAME OF DECEASED (Type or Print) (First) <u>Regina</u> (Middle) <u>E</u> (Last) <u>Hopcraft</u>			
4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>10</u> (Year) <u>1955</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> 8. DATE OF BIRTH <u>3/2/1897</u> 9. AGE last birthday <u>58</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Michial Grady</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Jesse Hopcraft Cumberland, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Malignant Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 8</u> , 19 <u>55</u> , to <u>Oct 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 10</u> , 19 <u>55</u> , and that death occurred at <u>10</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>E. J. Deane</u>				ADDRESS (Street, city, town, state) <u>25 Alder St. Oakland, Md.</u>		DATE SIGNED <u>10/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>10/11/55</u>		DATE THEREOF <u>10/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetry</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>10/11/55</u>		REGISTRAR'S SIGNATURE <u>Julia G. Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein, Inc. Cumberland, Md.</u>			

CERTIFICATE OF DEATH

8778

Reg. Dist. No. 12

1. NAME OF DECEASED (Print or Type)

2. PLACE OF DEATH

3. SEX (Male or Female)

4. AGE (Years, Months, Days)

5. OCCUPATION

6. MARITAL STATUS (Single, Married, Widowed, Divorced)

7. DATE OF BIRTH

8. PLACE OF BIRTH

9. CAUSE OF DEATH (Immediate Cause)

10. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. DATE OF DEATH

15. PLACE OF INTERMENT

16. NAME OF CEMETERY

17. TIME OF INTERMENT

18. SIGNATURE OF WITNESSES

19. SIGNATURE OF DECEASED

20. DATE OF SIGNATURE

21. SIGNATURE OF PHYSICIAN

22. SIGNATURE OF REGISTRAR

23. DATE OF SIGNATURE

24. SIGNATURE OF WITNESSES

25. SIGNATURE OF DECEASED

26. DATE OF SIGNATURE

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF REGISTRAR

29. DATE OF SIGNATURE

30. SIGNATURE OF WITNESSES

31. SIGNATURE OF DECEASED

32. DATE OF SIGNATURE

33. SIGNATURE OF PHYSICIAN

34. SIGNATURE OF REGISTRAR

35. DATE OF SIGNATURE

36. SIGNATURE OF WITNESSES

37. SIGNATURE OF DECEASED

38. DATE OF SIGNATURE

39. SIGNATURE OF PHYSICIAN

40. SIGNATURE OF REGISTRAR

41. DATE OF SIGNATURE

42. SIGNATURE OF WITNESSES

43. SIGNATURE OF DECEASED

44. DATE OF SIGNATURE

45. SIGNATURE OF PHYSICIAN

46. SIGNATURE OF REGISTRAR

47. DATE OF SIGNATURE

48. SIGNATURE OF WITNESSES

49. SIGNATURE OF DECEASED

50. DATE OF SIGNATURE

49. SIGNATURE OF PHYSICIAN

50. SIGNATURE OF REGISTRAR

51. DATE OF SIGNATURE

50. SIGNATURE OF WITNESSES

51. SIGNATURE OF DECEASED

52. DATE OF SIGNATURE

51. SIGNATURE OF PHYSICIAN

52. SIGNATURE OF REGISTRAR

53. DATE OF SIGNATURE

52. SIGNATURE OF WITNESSES

53. SIGNATURE OF DECEASED

54. DATE OF SIGNATURE

53. SIGNATURE OF PHYSICIAN

54. SIGNATURE OF REGISTRAR

55. DATE OF SIGNATURE

54. SIGNATURE OF WITNESSES

55. SIGNATURE OF DECEASED

56. DATE OF SIGNATURE

55. SIGNATURE OF PHYSICIAN

56. SIGNATURE OF REGISTRAR

57. DATE OF SIGNATURE

56. SIGNATURE OF WITNESSES

57. SIGNATURE OF DECEASED

58. DATE OF SIGNATURE

57. SIGNATURE OF PHYSICIAN

58. SIGNATURE OF REGISTRAR

59. DATE OF SIGNATURE

58. SIGNATURE OF WITNESSES

59. SIGNATURE OF DECEASED

60. DATE OF SIGNATURE

59. SIGNATURE OF PHYSICIAN

60. SIGNATURE OF REGISTRAR

61. DATE OF SIGNATURE

60. SIGNATURE OF WITNESSES

61. SIGNATURE OF DECEASED

62. DATE OF SIGNATURE

61. SIGNATURE OF PHYSICIAN

62. SIGNATURE OF REGISTRAR

63. DATE OF SIGNATURE

62. SIGNATURE OF WITNESSES

63. SIGNATURE OF DECEASED

64. DATE OF SIGNATURE

63. SIGNATURE OF PHYSICIAN

64. SIGNATURE OF REGISTRAR

65. DATE OF SIGNATURE

64. SIGNATURE OF WITNESSES

65. SIGNATURE OF DECEASED

66. DATE OF SIGNATURE

65. SIGNATURE OF PHYSICIAN

66. SIGNATURE OF REGISTRAR

67. DATE OF SIGNATURE

66. SIGNATURE OF WITNESSES

67. SIGNATURE OF DECEASED

68. DATE OF SIGNATURE

67. SIGNATURE OF PHYSICIAN

68. SIGNATURE OF REGISTRAR

69. DATE OF SIGNATURE

68. SIGNATURE OF WITNESSES

69. SIGNATURE OF DECEASED

70. DATE OF SIGNATURE

69. SIGNATURE OF PHYSICIAN

70. SIGNATURE OF REGISTRAR

71. DATE OF SIGNATURE

70. SIGNATURE OF WITNESSES

71. SIGNATURE OF DECEASED

72. DATE OF SIGNATURE

71. SIGNATURE OF PHYSICIAN

72. SIGNATURE OF REGISTRAR

73. DATE OF SIGNATURE

72. SIGNATURE OF WITNESSES

73. SIGNATURE OF DECEASED

74. DATE OF SIGNATURE

73. SIGNATURE OF PHYSICIAN

74. SIGNATURE OF REGISTRAR

75. DATE OF SIGNATURE

RECEIVED

BUREAU V. S.

NOV 8 1952

RECEIVED

NOV 13 1952

11/13/52

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

09787

Reg. Dist. No. 167

9779

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL GORMAN MD</u>				TOWN <u>RURAL GORMAN MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>EMORY ADOLPHOS LEWIS</u>				<u>OCT - 1 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JUNE - 9 - 1895</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MINER.</u>				<u>SWALLOW FALLS MD.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>PHILIP LEWIS</u>				<u>LYDIA SPEICHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>212-24-1741</u>		<u>MRS ESTELLA LEWIS. GERMANIA, W. VA. RT-1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>442X Acute Myocardial Infarction</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
<u>Cerebral Vascular Disease</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1955</u>, to <u>Oct 1, 1955</u>, that I last saw the deceased alive on <u>Sept 2, 1955</u>, and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, City, town, state)		DATE SIGNED			
<u>Ralph Calandella</u>		<u>1234 Main St. Baltimore, MD.</u>		<u>Oct 3 - 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT-4-1955</u>		<u>FRIEND CEMETERY</u>		<u>NEAR SWALLOW FALLS MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/5/55</u>		<u>Elmer C. Shaffer</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

CERTIFICATE OF DEATH

8779

GARRETT
Rosal (Gorman) WID

GARRETT
WID
Rosal (Gorman) WID

MALE WHITE
MINER
Philip Lewis

ENJOY ADOLPHUS LEWIS
MARRIED ONE - 4-18-30
SWALLOTT FALIS WID 1/2
LYDIA SPEICHER

313-34-1711 MRS. ESTHER LEWIS

Cont. Wagoner
Cont. Wagoner

BUREAU V. 3

2007 10 1955

4-1-22
J. L. C. C. C.

4-1-22
J. L. C. C. C.
C. L. A. 1-1-22 FRIEND CENTER
YEAR 2000
C. L. A. 1-1-22

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09788

9780

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>EMMITTSBURG</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Grantsville, Md.</u>		<u>2 weeks</u>		TOWN <u>EMMITTSBURG, MD.</u>		<u>10X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CATHERINE MARGARETHA MILLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 23 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 5, 1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cove, Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Hamft</u>				14. MOTHER'S MAIDEN NAME <u>ANNA M OESTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Christian Miller, Grantsville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						<u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bilateral bronchopneumonia</u>						<u>2 weeks</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 9, 1955</u> , to <u>Oct 23</u> , 1955, that I last saw the deceased alive on <u>Oct 23</u> , 1955, and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>G Paige Strong</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Pa.</u>		DATE SIGNED <u>Oct 24, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Ethel Broadwater</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	

10-10-65

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BATIMORE, IN

CERTIFICATE OF DEATH

Reg. Gen. 1965

1. LOCAL HEALTH DEPARTMENT OR STATE DEPARTMENT OF HEALTH

NAME AND ADDRESS OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

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BUREAU V. S.

OCT 28 1965

RECEIVED

Handwritten signature

MASSACHUSETTS

OFFICE OF THE REGISTRAR OF DEATHS

100 STATE STREET, BOSTON, MASSACHUSETTS 02109

TELEPHONE: 617-725-1111

FAX: 617-725-1111

INTERNET: www.mass.gov

E-MAIL: registrar@mass.gov

WWW: www.mass.gov

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9781

CERTIFICATE OF DEATH

09789

Reg. Dist. No. 163

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calverley</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bloomington</u>		<u>28 years</u>		TOWN <u>Bloomington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mollie</u> (Middle) <u>MARY</u> (Last) <u>Moorehead</u>				<u>Oct 28</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec 10, 1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Own home</u>		<u>Berth, W. Va.</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Conley</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Sam. Lecky Moorehead, Bloomington</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
199.1 IMMEDIATE CAUSE (A) <u>Tumor in abdomen</u>						<u>1 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Carcinomatosis</u>						<u>6 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1</u> , 19 <u>55</u> , to <u>10/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/28</u> , 19 <u>55</u> , and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>P. Berry</u>				ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>		DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>10-30-55</u>		<u>Philas Cemetery</u>		<u>Westport Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-30-55</u>		<u>Dorothy Pattison</u>		<u>Ed Bral</u>		<u>Westport, Md.</u>	

CERTIFICATE OF DEATH

Reg. One No. 10

1. Usual Residence, Home or Place of Birth

2. Date of Death

3. Cause of Death

4. Place of Death

5. Name of Physician

6. Name of Hospital

7. Name of Nurse

8. Name of Undertaker

9. Name of Coroner

10. Name of Registrar

11. Name of Burial Place

12. Name of Burial Place

13. Name of Burial Place

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BUREAU V. 2

1955

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9782 CERTIFICATE OF DEATH

09790

Reg. Dist. No. 161

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MID</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE</u>		LENGTH OF STAY (in this place) <u>20 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>RUSSELL BERNARD ROSE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 5 1955</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MARCH-15-1877</u>	
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROADER</u>		11. BIRTHPLACE (State or foreign country) <u>BRADDOCK PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RUSSELL ROSE</u>				14. MOTHER'S MAIDEN NAME <u>DEALYERS LISTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>EDWARD ROSE 895 B. ST. MEADVILLE PA.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				<u>7 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1952</u> , to <u>Oct 3 1955</u> , that I last saw the deceased alive on <u>Oct 3 1955</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Milton Zepfer</u> M.D.				ADDRESS (Street, city, town, state) <u>Friendsville Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE SIGNED <u>Oct 5 1955</u>			
24. REC'D BY REGISTRAR <u>Oct-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>BRADDOCK CEMETERY</u>		LOCATION (City, town, or county) (State) <u>NORTH BRADDOCK PA.</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth Frantz</u> Deputy		26. FUNERAL DIRECTOR'S ADDRESS <u>Emory Bolden OAKLAND MD.</u>					

SMOOTH CUTTING

1. The purpose of this form is to provide a uniform method of recording information on the death of a person. It is to be filled out by the person who has the most complete knowledge of the facts of the death. It is to be filled out as soon as possible after the death. It is to be filled out in the language of the deceased. It is to be filled out in the language of the deceased. It is to be filled out in the language of the deceased.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED: GARRATT
RESIDENCE: FRIENDSVILLE
DATE OF DEATH: 10/18/55

NAME OF DECEASED: RUSSELL
RESIDENCE: WIDOWED MARCH 18-1911

NAME OF DECEASED: RUSSELL
RESIDENCE: WIDOWED ROSE
DECEASED: EDWARD ROSE
RESIDENCE: WIDOWED ROSE
DECEASED: EDWARD ROSE
RESIDENCE: WIDOWED ROSE

BUREAU V. B.

OCT 7 1955

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RECEIVED
OCT-8-1955
BALTIMORE
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
BALTIMORE, MD

9783

CERTIFICATE OF DEATH

09781
166

Reg. Dist. No.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>GARRETT</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u> TOWN <u>OAKLAND</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVANS NURSING HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>GARRETT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u> TOWN <u>OAKLAND</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY E SEBOLD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 23 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>NOV. -21-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW SEBOLD</u>				14. MOTHER'S MAIDEN NAME <u>KATHRYN GROWER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>JOSEPH SEBOLD M^{rs} HENRY MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Failure - Acute</u>						<u>12 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arrhythmia</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Sclerotic Heart Disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-11, 1955, to 10-23, 1955, that I last saw the deceased alive on 9-7-1955, and that death occurred at 6:30 P.M. from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>582nd St OAKLAND MD 10-24-55</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT-26-1955</u>	NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEMETERY</u>		LOCATION (City, town, or county) (State) <u>OAKLAND MD.</u>		
24. REC'D BY REGISTRAR DATE <u>10/26/55</u>		REGISTRAR'S SIGNATURE <u>Julia A Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u> ADDRESS <u>OAKLAND MD.</u>			

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9784

CERTIFICATE OF DEATH

09792

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>		CITY <u>JENNINGS</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>OAKLAND</u>		<u>3</u> days		TOWN <u>JENNINGS</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JACOB</u> <u>STARK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 24, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <u>SINGLE</u> , MARRIED, WIDOWED, DIVORCED, (Specify) <u>✓</u>	8. DATE OF BIRTH <u>Sept 24, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woodman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Stark</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hetrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-2562</u>		17. INFORMANT & ADDRESS <u>Sheriff Paul Fisher, Oakland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>32 years</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Alcoholism</u>						<u>3 day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 21, 1955</u> , to <u>Oct 24, 1955</u> , that I last saw the deceased alive on <u>Oct 24, 1955</u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Chas. A. Rown</u> M.D.				ADDRESS (Street, city, town, state) <u>Oakland, Md.</u>		DATE SIGNED <u>8/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		LOCATION (City, town, or county) (State) <u>Bittinger, Garrett Co., Md.</u>	
24. RECD BY REGISTRAR <u>10/26/55</u>		REGISTRAR'S SIGNATURE <u>Julia A. Rown</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald F. Newman</u>		ADDRESS <u>Antonsville, Md.</u>	

CERTIFICATE OF DEATH

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6. PLACE OF BIRTH

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9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF DECEASED

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